PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, February 26, 2002, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Dr. Howard K. Koh, M.D., (Chairman), Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo, Ms. Janet Slemenda, and Dr. Thomas Sterne; Ms. Shane Kearney Masaschi and Mr. Benjamin Rubin absent (one vacancy). Also in attendance was Attorney Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

PERSONNEL ACTIONS:

In a letter dated February 13, 2002, Katherine Domoto, MD, MBA, Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the reappointments to the consultant and active medical staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the reappointments of physicians to the medical staffs of Tewksbury Hospital be approved as follows:

REAPPOINTMENTS:	**STATUS/SPECIALITY:**	**MEDICAL LICENSE NO.:**
Menekse Alpay, MD	Consultant Psychiatry	156783
Ayse Atasoylu, MD	Consultant Internal Medicine	161369
Ann Gurian, MD	Active Staff Psychiatry	71873

In a letter dated February 12, 2002, Blake Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of reappointments of physicians to the active and consulting medical staffs of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation . After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the reappointments of physicians to the active and consultant medical staff of Western Massachusetts Hospital be approved as follows:

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MEDICAL LICENSE NO.:**
Theodore King, M.D.	Pulmonary/Geriatric	56940
Arthur Sher, M.D.	Dermatology	35317

In a memorandum dated February 4, 2002, Howard K. Koh, M.D., Commissioner of Public Health, recommended approval of the appointment of Robert J. Walker to Program Manager VI (Deputy Director, Radiation Control Program). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority

of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Robert J. Walker to Program Manager VI (Deputy Director, Radiation Control Program) be approved.

STAFF PRESENTATION:

"MASSACHUSETTS BIRTHS 2000", BY CHRISTINE JUDGE, EPIDEMIOLOGIST, BUREAU OF HEALTH STATISTICS, RESEARCH AND EVALUATION; SALLY FOGERTY, ASSISTANT COMMISSIONER, BUREAU OF FAMILY AND COMMUNITY HEALTH; AND "BOSTON BIRTHS 2000", BY BARBARA FERRER, DEPUTY DIRECTOR, BOSTON PUBLIC HEALTH COMMISSION:

Ms. Christine Judge, Epidemiologist, Bureau of Health Statistics, Research and Evaluation, presented the "Massachusetts Births 2000" report. She said in part, "…Compared to the United States, Massachusetts is doing quite well on virtually all birth-related indicators. The Massachusetts teen birth rate, approximately twenty-six births per one thousand females ages fifteen to nineteen, was nearly half the U.S. rate of forty-nine births per thousand. The percentage of women beginning prenatal care in the first trimester was slightly higher in Massachusetts, 83.8 percent, compared with 83.2 percent for the U.S. The percentage of low infant mortality rate in Massachusetts was thirty-three percent below the U.S. rate and was lower than the U.S. rates for the largest racial and ethnic groups, as well….There has been a consistent improvement over the past decade in most Massachusetts birth indicators. The teen birth rate is down twenty-seven percent, and the overall infant mortality rate has declined thirty four percent since 1990. The infant mortality rates have been declining for all race and ethnicity groups, as well. However, the black non-Hispanic infant mortality rate has not been declining as much as those for white non-Hispanic and Hispanic infants. From 1990 to 2000, the infant mortality rate for black non Hispanics decreased by seven percent, compared with about forty percent among white non-Hispanic and Hispanic infants. The disparity between black and white infant mortality rates has not improved over the past decade. The one indicator that is not declining is low birth weight. It has risen about twenty-two percent since 1990…. Perinatal indicators in Massachusetts are very good. Infant mortality is the lowest in Massachusetts history. The teen birth rate continues to decline. Fewer women smoke during pregnancy each year. Four out of five women receive adequate prenatal care. Overall, Massachusetts birth indicators for 2000 are better than those for the U.S. Still, Massachusetts faces some challenges in improving the health of mothers and infants. Disparities in birth indicators persist in Massachusetts by race and ethnicity, education, mother's country of birth and city or town of residence. We will continue to follow trends in low birth weight, C-section rates, multiple births, infant mortality for different racial groups and Massachusetts'progress towards achieving the Healthy People 2010 targets. We need to recognize the importance of the birth certificate data for surveillance research and program development, such as newborn screening, high-risk infant identification, and immunization tracking. It is extremely important that all physicians, other medical professionals and hospital administrators sustain their efforts to provide timely data of the highest quality." Some highlights of the "Massachusetts Births 2000" report are listed below:

Highlights:

- **The infant mortality rate (IMR) is the lowest in Massachusetts history** (4.6 deaths per 1,000 live births). The IMR has declined 34% since 1990.

- **The teen birth rate continues its steady decline of the last ten years**. In 2000, the teen birth rate was 25.8 births per 1,000 females ages 15-19, compared to 26.7 in 1999. The teen birth rate has declined 27% since 1990.

- **Cesarean section delivery rates continue to increase in Massachusetts.** In 2000, 23.8% of all births to Massachusetts residents were delivered by c-section. This is a 6% increase from the 1999 c-section rate.

- **The percentage of women smoking during pregnancy decreased** from 10.7% in 1999 to 9.7% in 2000. The rate of smoking during pregnancy has decreased 50% since 1990 (19.3%).

- **The ten-year trend of increasing numbers of multiple births continues**. The percentage of multiple births increased slightly from 4.2% in 1999 to 4.3% of births in 2000. The percentage of multiple births in Massachusetts has increased 65% since 1990.

- **Disparities by race and ethnicity remain**. Despite decreasing infant mortality overall, there are great disparities in IMRs across racial and ethnic groups. The disparity between black and white infants is greatest, with blacks dying at 3 times the rate of whites. Black infants are also about twice as likely to be of low birthweight than white infants; Hispanic mothers are almost 5 times as likely to be under the age of 20 than white mothers, and lower percentages of black, Hispanic, Asian mothers receive adequate prenatal care than white mothers.

Number and Rate of Births

The number of births to MA residents rose by about 1% between 1999 and 2000, from 80,866 to 81,582. Since 1990, the number of births in Massachusetts has declined by 12%, and the birth rate has declined by 8% (from 62.1 to 57.2 births per 1,000 females ages 15-44).

Infant Mortality

The infant mortality rate (IMR) in 2000 was 4.6 infant deaths per 1,000 births, as compared to 5.2 in 1999. This is the lowest infant mortality rate in Massachusetts history and represents a 34% decline since 1990.

Decreases in IMRs occurred among white non-Hispanics (4.7 to 3.8) and Hispanics (5.5 to 5.2), while the IMR for black non-Hispanics increased from 12.3 to 12.8 from 1999 to 2000. The IMR for Asians increased from 1.9 to 4.1. Note: the IMR for Asians should be interpreted with caution due to the small number of infant deaths involved. Overall, decreases in infant mortality occurred among those deaths in the neonatal period (less than 28 days), while 3 more deaths occurred in the post-neonatal period in 2000 than in 1999.

Pregnancy-Associated Mortality

In 2000, 26 pregnancy-associated deaths, including 1 maternal death, occurred in Massachusetts. The pregnancy-associated mortality ratio (PAMR) was 31.4 per 100,000 live births, and the maternal mortality ratio (MMR) was 1.2 per 100,000 live births. Although there was some fluctuation in the PAMR and the MMR between 1990 and 2000, the differences are not statistically significant due to the small number of occurrences.

Teen Births

Teen births decreased between 1999 and 2000, from a total of 5,515 births to females ages 15-19 to 5,305 births. The rate in 2000 was 25.8 births per 1,000 females ages 5-19, a 3% decrease from the 1999 rate of 25.7. The teen birth rate in Massachusetts has declined by 27% since 1990.

Low Birthweight (LBW)

The percentage of births to low birthweight infants (infants weighing less than 5.5 pounds) remained the same as in 1999 (7.1%). Percentages of low birthweight remained the same among race/ethnicity groups between 1999 and 2000, except for black non-Hispanics, who experienced a slight decrease (12.2% to 12.0%) in the past year. LBW increased slightly among singletons, from 5.0 to 5.1. The increase occurred among mothers less than 35 years of age. LBW decreased slightly among multiples (54.5% to 53.0%) for the first time in six years. Very low birthweight (VLBW; infants weighing less than 3.3 pounds) remained stable between 1999 and 2000, at 1.4% of infants. Black non-Hispanic infants, who have the highest percentage of VLBW, experienced a small decrease in VLBWk from 3.6% in 1999 to 3.4% in 2000.

Preterm Deliveries

The percentage of preterm infants (delivered before the 37th week of gestation) increased from 7.6 % to 8.3%. The increase was among white non-Hispanic and black non-Hispanic infants, while Asian and Hispanic preterm rates remained stable. The percentage of preterm Hispanics increased by 8%, from 11.8 to 12.7%.

The percentage of infants delivered very early (before the 28th week of gestation) remained the same in 2000 as in 1999 (0.6%). As in 1999, the percentage of infants delivered before 28 weeks of gestation among black non-Hispanics in 2000 was more than double that of any other group (2.0%).

Births by Race, Hispanic Ethnicity, and Mother's Birthplace

Continuing the trend of the past 20 years, the percentage of births to white mothers decreased slightly, while the percentage of births to other race/ethnicity groups increased, especially among Asians.

In 2000, there was a substantial increase (30%) in births to mothers of Brazilian ethnicity in Massachusetts, from 799 births in 1999 to 1,033 births in 2000.

The percentage of births to non-U.S.-born mothers increased 7% between 1999 and 2000 – from 19.5% to 20.9%. In 2000, over 1 out of every 5 births to Massachusetts residents was to a mother born outside the continental U.S., Puerto Rico, and the U.S. Territories.

Smoking

The percentage of women who smoked during pregnancy decreased from 10.7% to 9.7%. Decreases were seen among white non-Hispanics and black non-Hispanics, groups with the highest prevalence of smoking during pregnancy. Rates for Hispanic and Asian women remained the same.

Prenatal Care

Adequacy of prenatal care decreased slightly from 79.4% in 1999 to 79.1% in 2000. Adequacy of prenatal care is a measure of the timing and number of prenatal care visits, not an assessment of the quality of prenatal care. The current measure used is the Kessner Index.

Cesarean Sections

The cesarean section delivery rates are increasing. The cesarean section rate among births to Massachusetts residents was 23.8%, up 6% from 1999 (22.4%). Increases were among both

primary and repeat c-sections. The primary c-section rate increased by 7%, from 16.6 to 17.7%, and the repeat c-section rate increased by 5%, from 71.6% to 75.2%. Accordingly, the rate of vaginal births after cesarean section (VBAC) deliveries decreased substantially, from 28.4% in 1999 to 24.8% in 2000.

Breastfeeding

The rate of mothers breastfeeding or intending to breastfeed increased – from 72.4% in 1999 to 73.8% in 2000. The rate increased for all major race/ethnicity groups, but the largest increase was among black non-Hispanic mothers (3% increase). The rate increased slightly for Asians, from 76.0% to 76.4%.

Public Source of Prenatal Care Payment

The percentage of mothers paying for prenatal care through a public source increased from 1999 to 2000 – from 26.8 to 27.5%.

Multiple Births

The percentage of multiple births (twins, triplets, and higher order) continues to increase; 4.3% of births in 2000 were multiples. This percentage has risen steadily over the past 10 years (2.6% in 1990). The increase in 2000 is attributable to mothers ages 35 and over (6.7% of these mothers gave birth to multiple infants). The percentage of multiples among births to mothers ages 35+ is almost double the percentage for mothers under age 35.

Comparison of Massachusetts Indicators to U.S.

Massachusetts perinatal health indicators were generally better than those for the U.S. in 2000.

According to final U.S. birth statistics and preliminary U.S. death statistics for 2000 comparisons were as follows:

The birth rate for women ages 15-44 in Massachusetts (57.2) was 15% lower than the U.S. birth rate (67.5).

The infant mortality rate (IMR) in Massachusetts (4.6) was 33% lower than the U.S. IMR (6.9).

The teen birth rate in Massachusetts (25.8) was 47% lower than the U.S. teen birth rate (48.5). The cesarean section delivery rate in Massachusetts (23.8%) was 4% higher than the U.S. c-section rate (22.9%).

The low birthweight rate in Massachusetts (7.1%) was 7% lower than the U.S. low birthweight rate (7.6%).

The percent of women receiving prenatal care in the first trimester in Massachusetts (83.8%) was slightly higher than the U.S.percentage (83.2%).

Ms. Sally Fogerty, Assistant Commissioner, Bureau of Family and Community Health, said in part, “I am delighted to follow this presentation because I think that it really represents all of the hard work of the Department since the 1980’s that we have been able to achieve this, and a good deal of that is due to this continued support of the Public Health Council in our moving forward with our programs….Basically, our major goal is healthy families. To have healthy families, we need to have healthy mothers, healthy fathers, and the two together will give us healthy babies and create healthy families….It is really critical that the services that women receive during pregnancy and at the time of birth are of the highest possible quality, that all barriers of receiving services are eliminated….I think one of the most significant findings is the

decrease in the number of women who are smoking both at the beginning of pregnancy and during pregnancy. We need to continue to help teens understand the dangers related to smoking, not just for their own health, but for that of their unborn children. We need to continue to look at the growing epidemic of obesity in adolescents…We know that there is an increased risk during pregnancy if a woman has diabetes. We know that there is a direct link between obesity and Type 2 Diabetes. These are the sort of issues that we are beginning to focus on at this point…"

Chairman Howard Koh, M.D. said in part, "…We have much to celebrate today. This report is, in fact, a celebration of our public health. When we discuss infant mortality in particular, we end up discussing public health in its totality…We are very proud that the infant mortality rate is the lowest in our state history, that we have one of the lowest infant mortality rates of any state in the country, probably the lowest of any diverse state in the country. Our teen birth rate is dropping, fewer women smoke and drink during pregnancy, but we have continued challenges with respect to meeting the needs of a diverse population and eliminating disparities, and I know we all agree that healthy babies can only come from a broad commitment, not only to healthy mothers, but to public health in general in an increasingly diverse population…This is a very exciting report."

Ms. Barbara Ferrer, Deputy Director, Boston Public Health Commission, presented **"Boston Births 2000."** Ms. Ferrer said in part, "…In the year 2000, there were about eight thousand, seventy-nine live births to Boston residents. Overall between 1990 and the year 2000, Boston births declined by about twenty-two percent. In the last four years in Boston, the number of live births has increased by about five percent. In 2000, births of black infants and white infants each accounted for about a third of all births to Boston residents. Twenty-two percent of the total births in Boston were Latino or Hispanic, and about eight percent were Asian. The distribution of births by maternal age differed somewhat from that of Massachusetts and it is worth noting here that there is generally a younger age distribution in the City of Boston. Nineteen percent of Boston births were to women age twenty to twenty-four, while only fifteen percent of Massachusetts births were to women in the same age group as you can see when you look at the number of births to women over thirty-five. This in part is explained by the fact that Boston has a younger population than other parts of the state. When looking at multiple births, the picture is also different in Boston. We have had a less dramatic increase in multiples during the past decade with an increase from about 2.7 percent of all births in 1990 to 3.6 percent of births in the year 2000. This is compared to 4.3 percent of the state's births that were to twins, triplets or other multiple order births. Again, here you can see that the distribution of multiple births by race and ethnicity is also different with their being more multiple births occurring among white women than any other race or ethnicity. We have some promising indicators we want to highlight. The first is similar to the state, a dramatic decrease in the birth rate to adolescents, ages fifteen to nineteen. In the year 2000, there were about seven hundred and eighty-five births to adolescents in Boston. This is about 9.7 percent of Boston births, a slight increase form 1999, but not a statistically significant one. Between 1992 and 2000, the Boston rates for teen births fell by thirty-six percent. However, similar to the state adolescent birth rates they continue to be substantially higher for Hispanics, 71.6 per thousand live births, and for blacks, 63.7 per thousand live births when compared to whites, where the rate is about ten per thousand births, and Asians where, again, it is about ten per thousand births. Smoking is important to look at because it is conclusively linked to poor birth outcomes; and, we too in Boston have enjoyed a tremendous decrease in the self-reporting of smoking during pregnancy. In 1992, fifteen percent of Boston mothers said that they smoked during their pregnancy…By 2000, we only have six percent of mothers who are pregnant in Boston, who are reporting smoking during pregnancy. This is about a sixty percent decline in about eight years. This is tremendous and huge…."

Ms. Ferrer continued, "Boston's low birth weight rate changed very little during the 1990's…Boston's very low birth weight rate has fluctuated in the last decade between 1.9 percent and 2.1 percent, and the extreme low birth weight rate has also fluctuated very little over

the last decade and stays between two and three births per thousand live births. In Boston, black babies are twice as likely as white babies to be under five and a half pounds at birth, and the disparity continues to exist year by year. There was also an increase both in the disparity between white and black births and low birth weight babies, and an increase within every single race and ethnic group on the percent of low birth weight babies that were born. Similar picture on very low birth weight babies. When we looked at this by race and ethnicity, black babies are three times more likely than white babies to be under 3.3 pounds at birth…"

Dr. Ferrer concluded, "…We have had some setbacks in efforts to improve outcomes and eliminate racial and ethnic disparities, and it is important to note these. We have had a big reduction in our federal support of the Boston Healthy Start Initiative. At its high point, we were receiving about seventeen million dollars a year of an effort to target racial disparities. We are down to about two million dollars a year. We have had significant cuts in state funding for the Home Visiting program…We have also had cuts in money that has been available to support case management, AIDS services, substance abuse services; and, surprisingly enough, big cuts in tobacco control which, dramatically accounts for poor birth outcomes. Yet, despite these major setbacks in funding, we do have some existing initiatives in the City of Boston that are working towards tackling the continuing problem of racial disparities in birth outcomes and improving all birth outcomes. We have a working group that is a leadership group, that advises us on the
health of women and infants. They have just begun to undertake a new fetal and infant mortality review that is actually a case by case review of infant deaths in the City of Boston. Our Boston Healthy Start Initiative has joined with the Women's Health Demonstration Project to actually emphasize case management services for women in between pregnancies…We have a Reach 2,010 project, which is also focused on reducing health disparities for women on breast and cervical cancer that looks at many of the issues around the health status of black women in the City of Boston, regardless of their childbearing status. We would like to mention that we have been strong advocates of the need to restore support for women's health-related programs, programs like the Healthy Start Insurance Program for women who are pregnant, and our Home Visiting programs, and that there need to be heightened efforts across the state to eliminate racial and ethnic disparities in health."

No Vote – Informational Only

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO REGULATIONS ENTITLED HEALTH INSURANCE CONSUMER PROTECTION REGULATIONS 105 CMR 128.000:

Ms. Karen Granoff, Director , Office of Patient Protection (OPP), said in part, "…The purpose of this memorandum is to brief the Public Health Council on amendments to 105 CMR 128.000 et seq. (Health Insurance Consumer Protection Regulations). This regulation was promulgated as an emergency regulation on January 1, 2001 and in final form on March 29, 2001, to implement the provisions of sections 13 through 16 of M.G.L.c. 1760 (Chapter 1760), for which the Department has responsibility.
Following this briefing, the Department will schedule a public hearing on the proposed amendments. The Office of Patient Protection has responsibility for the oversight of health insurance carriers' internal grievance procedures, certain guarantees of continuity of care and specialty care referral, and the process by which eligible insureds might request an external review of a carrier's adverse determination (a denial of coverage by a carrier based upon a determination that a requested service is not medically necessary). The regulation sets forth requirements in these areas. On January 8, 2002, the Department and the Division of Insurance, which is charged with responsibility for sections 2 through 12 of Chapter 1760, held a joint informational hearing to consider testimony on the first year of implementation of chapter 1760 and the regulations that had been promulgated by each agency. As a result of testimony offered at that hearing, and as a result of the experience of OPP during the first year of

implementation of chapter 1760 and the regulation, OPP is proposing to amend certain sections of 105 CMR 128.000 et.seq. The substantive changes are discussed below:

A. Definition of "Authorized Representative"

Both the statute and the regulation permit an insured to designate an authorized representative to pursue an appeal or grievance on behalf of an insured. OPP has encountered instances in which an insured designated a facility as an authorized representative. Since an authorized representative must be able to sign, inter alia, an authorization for the release of medical records, and must be available to answer questions, especially in the case of a request for an external review of a health plan decision, OPP found that appeals were being delayed until an individual was designated to act on the behalf of the insured. The proposed amendment to the definition will make it clear that there must be a named individual to serve as an authorized representative.

B. Notification at the End of the 3-Day Internal Inquiry Process

The regulation currently requires a carrier to provide a written notice to a member of the right to have an inquiry processed as a grievance, if the inquiry has not been resolved in three days. Carriers have indicated to OPP that this notice can be confusing to members whose inquiries are resolved orally shortly after the third day. For example, a carrier is now required to send a notice on day three that states that because the inquiry has not been resolved, the member has the right to have the inquiry treated as a grievance. If the carrier then orally resolves the grievance to the member's satisfaction on day four or five, it is confusing to the member when the letter arrives and often generates another call to the carrier. OPP is proposing to remove the requirement that the notice at the end of three days be in writing, which will permit the carrier to notify an insured by telephone of the right to pursue the unresolved inquiry as a grievance.

C. The 30-Business-Day Period for Resolution of a Grievance

The regulation currently states that the 30-business-day period in which a carrier must resolve a grievance begins to run on the date on which the member notifies the carrier that he or she is not satisfied with the carrier's response to an inquiry, if earlier than the three-day time period. Since a carrier would have no way of knowing that a member is not satisfied until it is notified by the member, regardless of whether the notice is before or after the third day, OPP proposed to delete the phrase "if earlier than the three business day period."

D. Written Agreement to Extend the Time Limits under 105 CMR 128.000

Certain sections of the regulation permit the carrier and the member to extend the time limits for resolution of grievances by mutual written agreement. OPP proposes to amend the regulation to make it clear that any such agreement must specify the duration of the extension (i.e., that the extension not be open-ended) and that in no event may the extension exceed an additional 30 business days.

E. Contents of the Final Adverse Determination

The regulation sets forth the information that carriers must provide in any final adverse determination. OPP proposes to add the requirement that carriers include information about expedited review so that members are aware of the right to request an external review on an expedited basis.

F. Rights Available to Members Who Receive an Adverse Determination Regarding an Inpatient Stay

The regulation currently provides a right to an expedited external review upon a finding by OPP, based upon a physician's certification, that "delay in the providing or continuation of health care services that are the subject of a final adverse determination would pose a serious and immediate threat to the health of the insured" (105 CMR 128.401). The regulation further provides that if the subject matter of the external review involves the termination of ongoing services, the insured may apply to the external review panel to seek the continuation of coverage for the terminated service during the period the review is pending" (105 CMR 128.414). OPP has noted that in some cases involving the termination of coverage for an inpatient stay, carriers have failed to appropriately notify members of these rights. OPP proposes a change that explicitly requires carriers to provide notice of these rights in adverse determinations regarding inpatient stays.

G. Carriers' Responsibility for Providing Medical Records to the External Review Agency

105 CMR 128.409 and 128.412 authorize the external review agency to request and obtain medical records necessary to review a case, and require that the records be provided within specified time periods. During the past year, OPP has had to intervene when carriers failed to provide materials to the external review agencies based on the mistaken assumption that it was not the responsibility of the carrier to provide the requested records. The proposed changes will clarify the cases in which the carrier is responsible for providing records. The proposed amendments also provide possible sanctions against carriers that fail to comply with the regulation.

H. Requests for Continuation of Services Pursuant to 105 CMR 128.414

An insured may request continuation of ongoing services during the external review period. OPP has noted requests for continuation of services that were not timely, e.g., in which insureds permitted up to two weeks to pass before requesting an external review and seeking continuation of ongoing services. As a result of OPP's experience and the testimony of carriers, OPP is proposing to add the requirements that such requests be submitted within 48 hours of the insured's receipt of the carrier's final adverse determination.

I. Standing Referrals for Specialty Care

Chapter 1760 added the right of an insured to receive a standing referral from a primary care physician (PCP) for specialty health care under the provisions set forth in section 15(f) of the statute and 105 CMR 128.505. OPP has received requests for assistance from insureds whose health plan administers some types of specialty care through a utilization review organization (URO) rather than through referrals from a PCP. In these instances, the insureds had to keep returning to the URO for repeated referrals or authorization despite the documentation by a treating physician that a standing referral would be appropriate. OPP is proposing to amend the regulation to make it clear that if carrier manages specialty care by some means other than PCP referrals, insureds have the same right to a standing referral in cases that meet the guidelines set forth in the statute and regulation.

J. Designation of OPP Contacts by a Carrier

OPP has had the experience with certain national carriers of being denied access to appeals managers or even being told that no one at the plan would speak with an OPP representative. OPP proposes that carriers be required to provide names and contact information of appeals personnel so that OPP can assist consumers with concerns on a timely basis.

OPP expects to return to the Public Health Council following the public hearing to provide a review of the testimony, to present any changes proposed in response to the testimony, and to request approval for final promulgation of the proposed amendments.

NO VOTE – INFORMATIONAL ONLY

INFORMATIONAL BRIEFING ON THE PROPOSED EXTENSION OF THE SEPTEMBER 27, 2001 REVISED DETERMINATION OF NEED GUIDELINES FOR CHRONIC DISEASE AND ACUTE INPATIENT REHABILITATION SERVICES:

Ms. Joyce James, Director, Determination of Need Program, said in part, "The purpose of this memorandum is to inform the Public Health Council of Staff's plans to release for public comment the proposed extension of the revised Determination of Need Guidelines for Chronic Disease and Acute Inpatient Rehabilitation Services. The proposed extension would allow the revised guidelines to remain in effect for another year, from March 26, 2002, to March 26, 2003. The Council adopted the revised guidelines on February 27, 2001 for a one-year period to meet the immediate demand for chronic disease and acute rehabilitation beds. During this time, applications, for new beds must be filed, acted on by the Department and the projects implemented by applicants. Department staff was also required to evaluate the existing bed need methodology for both services, and if appropriate, develop a new bed need formula with complete revisions of the September 6, 1985 Chronic Disease Hospital Report ("1985 Report") and the August 25, 1992 Determination of Need Guidelines for Acute Inpatient Rehabilitation Services ("1992 Guidelines"). The Technical Advisory Group for Chronic Disease and Acute Rehabilitation Services convened by the Department was to assist in this regard. Under the revised guidelines a total of three applications were filed in 2001. Two of the applications were approved in 2001 and the other is still pending. The Technical Advisory Group recommends, and Department staff agrees, that the revised guidelines should be extended for another year. Extending the time will give chronic disease and acute rehabilitation hospitals another year in which to add beds…. It will also allow sufficient time for a deliberate decision-making process in which certain issues will be addressed in determining need for chronic disease and acute rehabilitation beds. Such issues include the appropriateness of current approaches to determine bed need and count existing bed supply, as well as the potential impact of the changes in the system, including addition of the new beds, application of Prospective Payment System (PPS) reimbursement to chronic disease and acute rehabilitation hospitals, and closure of acute care hospitals. Following the public comment period, a request for extension of the expiration date of the revised guidelines will be presented to Council for adoption at its March 26, 2002 meeting."

NO VOTE – INFORMATIONAL ONLY

DETERMINATION OF NEED PROGRAM:

ALTERNATE PROCESS FOR TRANSFER OF OWNERSHIP APPLICATION:

PROJECT APPLICATON , NO. 5-3A14 OF REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATION – REQUEST FOR TRANSFER OF OWNERSHIP AND ORIGINAL LICENSURE OF REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS, RESULTING FROM AN AFFILIATION AGREEMENT IN WHICH PARTNERS REHABILITATION AND CONTINUING CARE SERVICES, INC. WILL BECOME THE SOLE MEMBER OF REHABILITATION HOSPITAL OF THE CAPE AND ISLANDS CORPORATION:

Ms. Joyce James, Director, Determination of Need Program, said in part, "…Rehabilitation Hospital of the Cape and Islands Corporation ("RHCI"), located at 311 Service Road, East Sandwich, MA, filed a Determination of Need application seeking approval for the transfer of ownership and original licensure of RHCI, which results from an Affiliation Agreement in which Partners Rehabilitation and Continuing Care Services, Inc. ("Partners Rehabilitation") will become the sole Member of RHCI. RHCI will remain the licensee of the Hospital. No change in services and no capital expenditures are contemplated for this transfer of ownership. Partners Rehabilitation was created on October 1, 2001, to oversee the non-acute providers in the Partners HealthCare System and to integrate the care they offer and the way in which they

operate. Partners HealthCare System is the sole member of Partners Rehabilitation, as it is of Brigham and Women's/Faulkner Hospitals, Inc.; The Massachusetts General Hospital; Newton-Wellesley HealthCare System, Inc.; and North Shore Medical Center, Inc. RHCI notes that it is already part of Partners HealthCare System, because the majority of RHCI Trustees also serve as its corporate members. Based upon a review of the application as submitted and clarification of issues by RHCI, staff finds that the application satisfies the requirements for the Alternate Process for Change of Ownership found in 105 CMR 100.600 et seq. Staff also finds that RHCI satisfies the standards applied under 100.602 as follow:

A. Individuals residing in the Hospital's primary service areas shall comprise a majority of the individuals responsible for decisions concerning:

    1. approval of borrowings in excess of $500,000

    2. additions or conversions which constitute substantial change in services;

    3. approval of capital and operating budgets

    4. approval of the filing of an application for determination of need.

B. RHCI has consulted with the Division of Medical Assistance (DMA) concerning the access of medical services to Medicaid recipients at its Hospital. Comments from the DMA indicate no access problems for Medicaid recipients in the Hospital's primary service area

C. The Division of Health Care Quality has determined that RHCI and any health care facility affiliates have not been found to have engaged in a pattern or practice in violation of the provisions of M.G.L. c.111,s 51 (D)

D. The Department has determined that RHCI, a non-acute care hospital, is not subject to the condition of approval to maintain or increase the percentage of gross patient service revenue allocated to free care, as defined at M.G.L. c. 118G or its successor statute covering uncompensated care, as existed prior to the transfer.

E. The Division of Health Care Quality has confirmed that RHCI is a licensed facility."

After consideration, upon motion made and duly seconded, it was voted: (Chairman Koh, Ms. Cudmore, Mr. George, Jr., Ms. Pompeo, Ms. Slemenda in favor; Dr. Sterne recused from discussion and vote; Ms. Kearney Masaschi and Mr. Rubin absent) **to approve Project Application No. 5-3A14 of Rehabilitation Hospital of the Cape and Islands Corporation – Request for transfer of ownership and original licensure of Rehabilitation Hospital of the Cape and Islands, resulting from an Affiliation Agreement in which Partners Rehabilitation and Continuing Care Services, Inc. will become the sole member of Rehabilitation Hospital of the Cape and Islands Corporation**.

COMPLIANCE MEMORANDUM:

PREVIOUSLY APPROVED DON PROJECT NO. 4-3951 OF CARITAS SOUTHWOOD HOSPITAL AND PROJECT NO. 4-3952 OF CARITAS NORWOOD HOSPITAL – PROGRESS REPORT ON COMPLIANCE WITH CONDITIONS OF APPROVAL FOR TRANSFER OF OWNERSHIP:

Ms. Joyce James, Director, Determination of Need Program, said in part, "The purpose of this memorandum is to report staff's findings and recommendation on Caritas Norwood Hospital's compliance with the condition of approval of Project No. 4-3951 and No. 4-3952. The projects relate to the transfer of ownership of Southwood Community Hospital, Inc. and Norwood

Hospital from Neponset Valley Health System, Inc. to Caritas Southwood Community Hospital, Inc. and Caritas Norwood Hospital, Inc. whose sole member is Caritas Christi. The Notices of Determination of Need issued December 12, 1997, required compliance with several conditions of approval. The conditions also directed staff to report on the status of compliance by the Council after consultation with Caritas Norwood and Neponset Valley Community Health Coalition. Since 1998, staff has been submitting annual progress reports to the Council based on annual compliance reports filed by Caritas Norwood and the Coalition. At the Public Health Council's December 19, 2000 meeting, the Council, based on staff's progress report, found that Caritas Norwood had fully complied with all the conditions of approval, except for those dealing with certain areas of mental health services, staffing, and landfill. The Council recommended that Caritas Norwood submit in one year a progress report on its compliance with these conditions. Staff's findings and recommendations indicated below are based on reports filed by Caritas Norwood on November 20, 2001, and by the Coalition on November 6, 2001. Letters were later submitted in February 2002, by Caritas Norwood and by the Coalition….Based on annual reports filed by Caritas Norwood Hospital and Neponset Valley Community Health Coalition in Fiscal Year 2002, we find that Caritas Norwood is in significant compliance with the conditions relating to mental health services, adequate staffing of the hospital's units, landfill and governance. We also find that Caritas Norwood requires additional time to be in full compliance with these conditions. We recommend that a year from now Caritas Nowrwood submit a report on its progress, including its collaborative efforts with the coalition to achieve full compliance of this condition."

Ms. Delia O'Connor, President of Caritas Norwood and Caritas Southwood Hospitals, and Mrs. Laurie Martinelli and Ms.Phyllis Boucher from the Coalition were available for questions but did not address the Council.

After consideration, upon motion made and duly seconded, it was voted: (unanimously) **to approve staff's recommendation that Caritas Southwood Community and Caritas Norwood Hospitals be directed to submit a further update to the Council in one year on its progress in complying with all the conditions of its approved DoN Projects No. 4-3951 and No. 4-3952, and that staff be directed to report its findings to the Public Health Council.**

The meeting adjourned at 11:30 a.m.

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Howard K. Koh, M.D., M.P.H.
Chairman, PHC

LMH/SB